PRINTED: 07/16/2009 FORM APPROVED

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NVS6551ICF		NVS6551ICF		B. WING		06/24/2009		
NAME OF PROVIDER OR SUPPLIER MISSION PINES NURSING & REHABILITATION CTR			STREET ADDRESS, CITY, STATE, ZIP CODE 2860 E. CHEYENNE AVENUE NORTH LAS VEGAS, NV 89030					
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR		ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE		
W 000	This Statement of De a result of complaint your facility on 6/24/0 Nevada Administrativ Intermediate Care Factor Complaint #NV00022 deficiencies cited (Sector W155). A Plan of Correction The POC must relate and prevent such occurrenced completion established to assure be included. Monitoring visits may on-going compliance requirements. The findings and con by the Health Division prohibiting any criminactions or other claims	eficiencies was generate investigation conducted (D9, in accordance with we Code, Chapter 449, acilities. 2173 was substantiated are Tags W104, W108 are to the care of all patient currences in the future. dates and mechanism (expression of the ongoing compliance of the ongoing	d in I with Ind I with Ind I with I with	W 000				
W 104 SS=H	state or local laws.			W 104				
	4. Cleaning of the prequipment must be protect the health of and staff. The facility necessary cleaning a equipment with storal appropriate procedur cleaning and routine evidenced by a clean	performed as needed of the residents when must have the and maintenance ge facilities and res for regular maintenance as						

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS6551ICF 06/24/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 E. CHEYENNE AVENUE MISSION PINES NURSING & REHABILITATION CTR NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 104 W 104 Continued From page 1 maintained and in good repair. Cleaning equipment, cleaning agents, aerosol cans and other hazardous chemical agents must be stored in areas separate from clean linen, food and other supplies and be inaccessible to residents. Dirty linen storage must be separate from the storage of clean linen, food and other supplies. Items for personal use, such as combs, toothbrushes, towels, bar soap and other similar items, must not be used in common. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to maintain a sanitary environment for residents in the facility as follows: a. The floors within the building, including the residents' rooms, were sticky and with brown stains. b. Dead roaches were observed in the hallways and one big roach crawled by the nurses' station. c. Multiple flies were observed within the hallways and the residents' rooms. d. A pink plastic basin with trash was left on the floor in the hallway. e. A wash cloth was hanging on the hand rail in the 400 hall. f. Gloves were observed on the floor in multiple hallways. g. Ketchup, salt and pepper packets were seen on the floor. h. A soiled brief in a clear plastic bag was found on the floor by the entrance to a resident's room. i. Interviews with six residents revealed that it

was "normal" to find flies and roaches within the

building.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		NVS6551ICF		B. WING		06/24/2009			
·				RESS, CITY, STA	ATE, ZIP CODE				
MISSION I	PINES NURSING & REH	ABILITATION CTR		HEYENNE AVENUE AS VEGAS, NV 89030					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE ROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
W 104	Continued From page 2			W 104					
	The facility was cited for environmental concerns at the annual recertification surveys conducted on 9/19/08 and in 2007. This deficiency was also cited as a result of an earlier complaint investigation conducted on 6/1/09. Severity 3 Scope 2								
W 108 SS=D	449.695 LAUNDRY REQUIREMENTS			W 108					
	Based on observation failed to collect and treprevent contamination	e laundry in in a sanitary dry must not be areas used for food. Soiled d and stored in prevent in linen. A provided for the	ility						
W 155 SS=D	Section 40 1. A facility must prove services which assure resident receives treamedications, diets an services as prescribe all hours of each day.	vide health e that each atments, d other health d and planned,		W 155					

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FORM APPROVED Bureau of Health Care Quality & Compliance STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING NVS6551ICF 06/24/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2860 E. CHEYENNE AVENUE MISSION PINES NURSING & REHABILITATION CTR NORTH LAS VEGAS, NV 89030 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) W 155 Continued From page 3 W 155 This Regulation is not met as evidenced by: Based on record review and interview, the facility failed obtain a stool sampled to test for Clostridium difficile in accordance with a physician's order for 1 of 6 residents. (Resident #3) Severity 2 Scope 1